Appendix C **Medicaid Home and Community-Based Services** **JURISDICTION:**

Reportable Event (RE) Form – RE Number:

☐ **MDCSW –** Send to DHMH ☐ **LAH –** Send to DHMH ☐ **Older Adults –** Send to MDoA
☐ **RTC –** Send to DHMH ☐ **Autism –** Send to MSDE ☐ **Model –** Send to DHMH

REPORTING INFORMATION (Check/enter all that apply)

Initial Telephone Report: ☐ **CM** ☐ **OSA** ☐ **OHS** ☐ **PROVIDER**
Date/Time of Telephone Report: /
Name of Reporter:
Title/Agency (if applicable):
Relationship to Participant/Applicant:
Phone: ext.
Email Address:
Person Completing the Form:
Date Form Completed and sent to CM:
Name (If different from reporter)**:**
Title/Agency (if applicable):
Relationship to Participant/Applicant:
Phone: ext.
Email Address:

EVENT INFORMATION (Check/enter all that apply)

Event Date/Time: /
Event Type: ☐ **Incident** ☐ **Complaint** ☐ **Both**
Participant/Applicant Name:
Address:
City/State/Zip:
Enter MA#:
DOB: Gender: ☐ **M** ☐ **F**
CM Name:
Provider Information (If involved or present):
Provider#: Provider Type:
Agency/ALF Name (if applicable**):**
Contact Person:
Phone: ext.
Date of Service Interruption (if applicable)**: Start: End:**

ALLEGED INCIDENT(S) (Check/enter all that apply)

Abuse: ☐ Physical ☐ Sexual ☐ Verbal ☐ Emotional **Neglect:** ☐ Nutrition ☐ Medical ☐ Self ☐ Environment

Accident/Injury (Requiring Treatment beyond First Aid)**:** ☐ Fall ☐ Fracture ☐ Burn ☐ Laceration/Wound ☐ Other

Emergency Room Visit: ☐ **Hospitalization:** ☐ **In-Patient Psychiatric Hospitalization:** ☐ **Death:** ☐ **Suicide:** ☐ **Suicide Attempt:** ☐

Abandonment: ☐ **Elopement/Missing Person:** ☐ **Exploitation:** ☐ Financial / Theft **Rights Violation:** ☐

Seclusion/Restraint: ☐ Physical ☐ Chemical ☐ Involuntary Seclusion

Treatment Error: ☐ Medication ☐ Other Treatment Error: **Other Incident Type:** ☐

COMPLAINT (Check/enter all that apply)

Quality of Care/Service Issue: ☐ **Other:** ☐ **Phone: ext. Email Address:**

Name of Complainant: **Address:** **City/State/Zip:**

Explain dissatisfaction with any aspect of the program's operations, activities, or administration under the Description of Event section on pg. 2.

Appendix C

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:
Event Date:

DESCRIPTION OF EVENT AND RESPONSE **This section must be completed by the Provider/Participant/Family/Other and should include a description of the incident and/or complaint (event) and what actions were taken to appropriately respond to the event. If applicable, complete Contact Information page**
SUBMIT WRITTEN RE FORM TO THE CM WITHIN REQUIRED TIMEFRAMES: 7 DAYS OF THE EVENT DATE. **THE DESCRIPTION SHOULD INCLUDE THE FOLLOWING INFORMATION:** **Immediate actions taken to safeguard the participant;** **Names and title(s) of individual(s) present at time of event;** **Diagnosis: (For ER visits or hospitalizations);** **Current status of the participant prior to submission of this report to the CM;** **Any other important information that fully describes the event** **Is other documentation attached?** (e.g. discharge summary, ALF incident report, additional handwritten pages)**:** ☐ **Yes** ☐ **No** **DESCRIPTION OF EVENT (Handwritten entries must be printed and legible):**

Appendix C

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name: **Case Manager/Service Coordinator:**

Event Date:

CONTACT INFORMATION **This section must be completed. All applicable agencies or individuals should be contacted**.					
Select all agencies/individuals contacted	**Contact Name**	**Date**	**Telephone #**	**Email**	**Address**
☐ **Case Manager**					
☐ **OSA**					
☐ **Law Enforcement Agency**					
☐ **Adult (APS) or Child Protective Services (CPS) *** (APS or CPS MUST be contacted for all alleged abuse, neglect or exploitation events.)					
☐ **Office of Health Care Quality**					
☐ **Authorized Guardian/Representative/Family** *Participant Authorized Release ☐ YES ☐ NO Date of Release:					
☐ **Ombudsman Program**					
☐ **Local School System**					
☐ **Other:**					

Comments:

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:
Event Date:

CM/OSA INTERVENTION AND ACTION PLAN(S)
This section must be completed by the CM/OSA. A copy of the RE form must be maintained in the participant/applicant file and a copy must be sent to the OSA, if applicable.

SUBMIT COMPLETED RE FORM TO THE OSA WITHIN REQUIRED TIMEFRAMES: 7 DAYS FROM THE EVENT DATE.

RESPOND TO ALL APPLICABLE QUESTIONS:

The provider/participant/family/other responded to the event appropriately? ☐ **Yes** ☐ **No** ☐ **N/A**

The provider/participant/family/other contacted APS/CPS if the event was abuse, neglect, or exploitation? ☐ **Yes** ☐ **No** ☐ **N/A**

The provider contacted the guardian/representative? ☐ **Yes** ☐ **No** ☐ **N/A**

The participant was provided with their right to appeal for an adverse action (*e.g.* denial or reduction of services)? ☐ **Yes** ☐ **No** ☐ **N/A**

Describe Findings, Interventions, Follow-up, and Corrective Action Plan(s):

To be completed by OSA only
Date Report received:

OSA Review Needed: ☐ **Yes** ☐ **No** **OSA Staff Assigned:**

Assignment Date: Review Due Date: Case Closure date: Status Letter Date (if applicable):